**Barnsley CCG - Delivering the GPFV – Transformation Plan**

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| **Area of plan** | **Description** |
| **Vision**  A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View | **Background and Vision**  NHS Barnsley Clinical Commissioning Group (BCCG) in conjunction with its member practices has been pursuing an ambitious 5 year strategy for the further development of Primary Care in Barnsley. This commenced in 2015 with a vision that over the next five years our goal would be to realise a wider model of out of hospital primary care in which patients and the public in Barnsley receive:   * support to manage long term conditions; * fast, responsive access to services; * proactive and coordinated care; * holistic and person centred care; * consistently high quality care; resulting in, * Improved health outcomes.   Our vision is a future in which the current model of primary care is allowed to deliver its full potential and adapt to meet the challenges of the future. It is for an integrated wider primary and community care offer, which is comprehensive and serving the full range of need found in the community, while doing more to reduce inequalities faced by Barnsley people and ensure parity of esteem for mental health care and support. It goes beyond medicine, reaching into communities and supporting people to live well for longer before they need to access healthcare.  The pillars of the 2015-2020 BCCG Primary Care Strategy were:-   * Estates * Workforce * Information Technology * Delivering Primary Care at Scale     This strategy obviously predated the GP Forward View (GPFV) published in April 2016, however there is a clear correlation between the two and the BCCG Primary Care Strategy reflects key strands of activity which contribute to the delivery of the GPFV key areas of focus around; investment, workforce, workload infrastructure and care redesign.  Considerable progress has been made under the four pillars described and further initiatives are planned, this document provides details on our progress to date whilst also outlining the future planned initiatives and those which are being considered to both strengthen primary care and offer a more comprehensive out of hospital offer that fully aligns with the national strategy outlined in the GPFV.  **Workforce**  In Barnsley it has been recognised that the number of GP’s is significantly lower than the England average, with only 54 GPs per 100,000 population against the national average of over 65 per 100,000 population (HSCIC Workforce Census 2015), and alongside this, the age profile of GP’s is increasing and there are challenges recruiting GP’s.  Our Primary Care developments are therefore designed to increase the wider primary care workforce and maximise the use of resources available.  In order to stabilise recurrent investment streams into primary care and encourage all practices to commit to local commissioned services that move services out of the acute hospital setting in an equitable way that ensures access to these services for all Barnsley patients, the concept of a Practice Delivery Agreement and local quality framework was co-produced by the clinical commissioning group and its member practices to:-   * Invest in the primary care infrastructure to deliver high quality equitable services for the registered population of Barnsley as close to home as possible * Support primary care sustainability through a longer-term investment profile * Deliver a targeted approach to the demographic health challenges on a Barnsley footprint and on a local practice basis through the Health Inequalities Targeted Schemes (HITS) * Build a mutually accountable relationship that is centred on improving health outcomes in Barnsley   The recurrent investment of over £4million per year in the Practice Delivery Agreement and Barnsley Quality Framework has enabled practices to employ additional staff and pilot new roles – examples include salaried GP’s, nursing staff, care navigation, therapy staff and alternative care home models. Further work will be required to fully understand the impact of this funding in terms of the numbers of additional staff, the roles being undertaken and the impact this has had to inform the ongoing development of the PDA over the period of the GPFV.  Other workforce initiatives aimed at improving the capacity and productivity of primary care have included**:**   * A locally commissioned **Clinical Pharmacist programme** to integrate the role into General Practice. In 2016/17 this has seen 15 Pharmacists with a strategic support team of 6 (1 Manager and 5 Administrators) employed to work within GP practices across Barnsley who will receive a co-ordinated induction and development programme. The aim of the programme is to increase the capacity of GP’s and Practice Nurses through the principle of patients being treated by the right clinician at the right time. The addition of Clinical Pharmacists within practices will also increase quality and safety in prescribing; maximise cost effective prescribing and reduce prescribing queries, complementing and enhancing the existing successful medicines management team. * The development of a **primary care training / Health Care Assistant Apprenticeship programme** aimed at encouraging administrative staff to become Health Care Assistants and for Health Care Assistants to receive further clinical skills training. This has seen the development of a locally commissioned Apprenticeship Programme – that has particularly focused on increasing clinical capacity and skill mix to support primary care teams and support the delivery of the year of care initiative to improve support for patients with long term conditions. This initiative will also support changes in roles currently undertaken in practice to improve alignment of the existing skill base ensuring the right people are delivering the right care interventions. In 2016/17 16 new apprentice placements have been created in GP practices.   Investment of £1.5million per year has been made to support these two schemes and therefore they will continue to be developed over the period of this plan and funded on a recurrent basis.  **Plans for the future include:-**  Building upon the work undertaken to date to deliver improved capacity in Primary Care, the CCG in partnership with our membership and other partners have identified a number of other schemes to increase the primary care workforce and attract GP’s to work in Barnsley.  The CCG will implement with partners, a **GP Fellowship Scheme,** initially for up to 6 newly qualified and new to Barnsley GP’s. The 2 year rotational fellowship programme will provide added value to their professional expertise and will support recruitment and retention and working in new models of care delivery.  A scoping exercise will be undertaken to identify the potential for the development of a **Practice Nurse and Advanced Nurse Practitioner training programme** to address other workforce elements of the Primary Care Strategy.  The CCG will also seek to further develop the **Vocational Training Scheme** in Barnsley to support the achievement of our ambitious aspiration to achieve training practice standards at all practices in Barnsley whilst accepting that not all practices will be trainers. The number of Training Practices in Barnsley has increased only marginally over the last 25 years, and expansion of the scheme is intended to improve recruitment and retention. Locality working and buddying systems will be explored as ways of managing training rotations across the borough.  The CCG will utilise the £22,000 of centrally provided funding in 2016/17 to support training in practices to begin to roll out our First Port of Call (FPOC) training programme across all practices and begin to develop receptionist / care navigation roles to harness the significant untapped potential within this element of the workforce. Taking on learning from the Wakefield Vanguard Model the funding from 2017/18 will be used to further develop the programme to enhance the role of receptionists as care navigators. The FPOC approach is based upon the premise that reception staff are the first point of access in General Practice and that they should have a positive influence upon the start of the patient journey by being:  **F**irst – **FRIENDLY**  **P**ort – **POLITE**  **O**f – **ORGANISED**  **C**all – **COMPASSIONATE**  As the CCG’s moves towards developing the receptionist role towards care navigation, this will also support our ambition that patients can easily access the right services, in the right place at the right time, supported by our social prescribing scheme ‘My Best Life’.  In November 2016 the CCG held a successful Workforce Summit involving stakeholders from Health Education England, the Deanery, Vocational Training Scheme, NHSE, the CCG, Barnsley Healthcare Federation, the Local Medical Committee and wider practice teams which explore further workforce developments and new roles that would further enhance our current plans. The theme was to review our current schemes and plans viewed through a film called **General Practice Jigsaw** and to identify gaps and opportunities to improve workforce capacity and planning.    The key outputs from the event included:   1. Each practice owning a learning and teaching ethos. 2. Significantly expanding undergraduate and postgraduate primary care nursing placements in Barnsley. 3. Expanding the opportunity extended to practices to become or participate in GP vocational training. 4. Establishing a key link person from Health Education England to help drive forward some of the Barnsley Plans.   **Workload Plans**  In addition to recognising the workforce challenges, it is equally important to address the workload challenges in Primary Care as the CCG seek to move care closer to home and deliver more care outside of hospital. The CCG has already implemented a number of schemes aimed at maximising the use of resources across primary care and taking some of the workload away from GP’s to release capacity. Examples include ‘Pharmacy First’, a minor ailment scheme and the Primary Care Eye Assessment and Referral Scheme (PEARS).  In order to address the workload issues across primary and build on the initiatives already in place, the CCG plans include the development of ‘Primary Care at Scale’ as well as maximising the impact of the workforce initiatives to develop capacity to deal with increasing workload pressures.  Barnsley CCG already has an at scale Federation in place, Barnsley Health Care Federation (BHF)’ and in line with the aspiration set out in the GPFV the CCG will continue to support BHF to play a central part in developing new models of care, through the development of a Multispecialty Provider model which will integrate the provision of primary and community services.  The CCG is currently working in partnership with both BHF and the Local Medical Committee (LMC) in order to develop a local scheme to support struggling practices. The coproduced “**The Practice Doctor**” scheme will provide a combination of local expertise and private providers to wrap a support package around practices. In signing up to the scheme practices will be supported to develop their own plan, in agreement with the CCG, to deliver sustainability and key outcomes for registered patients. The CCG will explore the opportunity to access the funding available through the General Practice Resilience Funding linked to the proposals around Productive Primary Care. It is anticipated that this scheme will commence during 2017 subject to approval of the business case and availability of funding from the available sources of investment.  Barnsley Healthcare Federation have worked with the CCG to develop proposals to provide a full programme of **Productive Primary Care** across all practices, linking in to the ‘Practice Doctor’ work to support practices who may be struggling with capacity due to staffing or other capacity issues as well as supporting all practices to maximise the use of resources through increased practice productivity. This initiative will increase both the efficiency and effectiveness of practices and will be delivered in partnership with practices improving demand management. An application has been made to NHS England for funding to support this programme through vulnerable practice/resilience funding and productive general practice programme. If this is successful the programme will begin to be rolled out to practices from the final quarter of 2016/17.  In order to improve the impact of workload associated with Care Home residents the CCG is currently working up proposals to deliver increased collaboration and alignment between practices and Care Homes.  Workload associated with deprivation is being addressed in a number of ways; Barnsley has developed PDA sister scheme the Health Inequalities Targeted Scheme (HITS) that targets differential investment to address areas of the borough with greatest health needs.  **Infrastructure**  As part of the overarching STP development in South Yorkshire and Bassetlaw, integration will be essential to deliver the out of hospital ambition.  In Barnsley the CCG is working collectively with healthcare providers, the Local Authority and other community partners to ensure that local strategies for out-of-hospital care include appropriate plans for premises development. This includes working with other commissioners, healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties through the use of all available commissioning levers.  The Primary Care estate in Barnsley is varied, ranging in both size and quality. To support the delivery of our Primary Care Strategy, having a fit for purpose estate is seen as one of the keys to success and therefore it is important to understand the fitness for purpose of the premises used for the delivery of primary care services, both in terms of delivery of core primary care, and potential to deliver more out-of-hospital services. To gain this understanding a whole system review of current premises stock, including space utilisation and fitness for purpose for the short, medium and longer term was required.  A full review of the premises being used to deliver primary care services by General Practices was commissioned by the CCG in 2015. The service specification required the undertaking of a six facet survey as well as assessing the Care Quality Commission Outcome 10 in all GP surgery premises. This review informed estates investment priorities and the CCG invested in work programmes to ensure premises met statutory requirements. This was funded by the CCG with an investment commitment of £500,000. The information gleaned also supported the development of a local place based Estates Strategy and plans for capital investments via the Estates and Technology Transformation Fund (ETTF) to support the improvement of the Primary Care Estate in Barnsley.  We recognise that there will be limited resources available for capital developments in future and this will mean that the CCG will have to maximise use of existing buildings, with new builds being approved only when all existing resources have been exhausted. The ETTF does however offer us an opportunity to improve the primary care estate in Barnsley.  Barnsley CCG submitted seven Schemes for ETTF funding. Three of these were feasibility studies for potential new build premises linked to future housing developments across the borough. Two of these, for potential premises at Brierley and Brampton are being taken forward as part of cohort 1 and will see investment of £456,000 during 2016/17. The third which relates to the feasibility of new health centre at Monk Bretton will be taken forward as part of cohort 2 with investment of £540,000 between 2017 and 2019. In addition a new build practice is currently being delivered in the town centre from previous NHSE capital funding.  The other schemes submitted for ETTF funding related to both workload and care redesign. Two of these have been included in cohort 2 for potential investment between 2017 and 2019. These schemes will see the development and roll out of mobile working across all GP Practices (£896,920) and the development of a third hub for extended GP access services through iHEART Barnsley (£526,000).  The continued development and implementation of the Local Digital Roadmap (LDR) in Barnsley will also support further integration of systems and improve the ability to share information (where appropriate) to improve patient care but also to improve the efficiency and effectiveness of care processes by ensuring medical professionals are able to access the information they need.  The CCG has already implemented the Medical Interoperability Gateway (MIG) in Barnsley which is allowing access to GP records in other healthcare settings. We plan to roll this out across health and care during 2016/17 and 2017/18 so that medical records can be viewed across primary, secondary and community care as well as by other health and care providers such as Ambulance Services, the Hospice and Social Care. The current investment in the MIG is £30,000 per year however there could be additional investment requirements as the system is rolled out and the number of users’ increases.  The CCG have invested in technology to support GP practices to deliver more services over the telephone and on-line through the roll out of a Voice Connects system which enables patients to book and cancel appointments and to order repeat prescriptions 24 hours per day, 7 days per week.  To support the development of primary care at scale BHF are also developing a centralised back office function offer to practices which will be designed to support them to better manage workload, as well as providing the infrastructure to be able to harness the advances in technology and capture economies of scale. The scheme would require approximately £45,000 for implementation and will specifically aim to   * Accelerate progress towards paper free at the point of care within general practice * Promote best practice * Support for more integration across the wider health and care system * Reduce workload in practices; * Support practices who want to work together to operate at scale * Support greater efficiency across the whole system * Increase interoperability across Practices and health and social care   **Care Redesign**  Barnsley CCG has commenced working with partners across health and care on an ambitious plan to deliver new models of care and integrated ways of working to deliver both efficiencies as well as reducing the care quality gap. The overall plan is supported by a number of key building blocks that are already in place these include:-   * A well-developed Community Interest Company – Barnsley Healthcare Federation with 80% of the practices as members * A well-developed plan to deliver an Accountable Care Organisation * A successful extended GP access programme running from 2 hubs, with plans to develop a third and further increase appointments on evenings and at weekends   The role out of the Map of Medicine across practices has also commenced which will enable refined care pathways to be consistently followed for all patients. As pathways are reviewed and included in the Map of Medicine tool, consideration will be given to ensuring that patients are receiving the right care and support in the right place and at the right time and will include a focus on self-management and self-care.  The CCG is currently working with all system partners to develop an alliance arrangement to deliver more integrated urgent care and emergency care pathways which will bring together all partners including GP Out of Hours providers and Extended Hours and NHS 111 providers to deliver the Commissioning Standards for Integrated Urgent Care. The Out of Hours element will be procured during 2017/18, with the provider being expected to work with partners to identify and deliver innovative solutions to provide integrated services.  During 2017/18 the CCG will begin to develop a locality model for the delivery of care closer to home including Primary Care. The locality model is in the early stages of development however 2017/18 will see the implementation of new models of delivery for some services such as Community Nursing, based around six localities which will ensure better alignment with and support for primary care. The six localities are mapped to Local Authority Area Councils.  We will also begin to see changes in the way in which GP and other medical consultations take place. New technology is already playing an important role in improving patient care. Practices in Barnsley are moving to universal digital records, offering online transactions including online registration, appointment booking, ordering of repeat prescriptions and viewing of medical records. We will be looking to build upon this and work with BHF as part of the proposals for back office functions and other developments. The CCG will be looking to implement new technology which will enable online/video consultations for patients. We will look to access the national funding for online general practice consultation software systems to provide the technology across practices to enable the roll out of online consultations. |
| **Investment in primary care**  The investment plan (revenue and capital) in primary care to deliver all aspects of the General Practice Forward View, locally. Including:   1. High level modelling that provides evidence of:  * the shift of activity from hospital to out of hospital care * total spend trajectories for the shift to primary care  1. Clarity on the resource shift so the STP can be clear on the new out of hospital /primary care expenditure plan –per capita shift to primary care and total spend reflecting the direction of travel for increased investment in primary care. 2. The CCG’s proposed on-going investment plans and timescales for making this investment in-line with delivery of the service offer above (including where CCGs require access to supporting additional non-recurrent transformation resources)? | Barnsley CCG opted for first wave fully delegated Primary Care Co – Commissioning. At this point the CCG’s 2015/16 programme allocation was above target (9%); whilst, in stark contrast, Barnsley was the only area in South Yorkshire to be below target in terms of primary care expenditure (5%). Taking on delegated responsibility for commissioning Primary Medical Services presented an opportunity to begin to redress this position.  The CCG has invested significantly above the Co-Commissioning budget since 2015/16 with additional funding of circa £4million per year on the Practice Delivery Agreement (PDA) and Health Inequalities Targeted Scheme (HITS). A further £1.5million per year (from 2016/17) to support the Clinical Pharmacist Programme. This is an addition to the funding of approximately £3m which remains in place to support other aspects of primary care including GP IT, Enhanced Services and Out of Hours.  Separately the CCG has invested in services to wrap around primary care, this includes, RightCare Barnsley – our successful brokerage service, enhancing the intermediate care provision from an alliance contract. The CCG has also procured a full social prescribing service which is due to commence on 01 April 2017.  The £4 Million local investment in primary care was enhanced by the successful Prime Ministers Challenge Fund bid/pilot that brought a further £2.3 million to Barnsley to increase access to primary care on evenings and at weekends. This funding will continue between October 2016/17 and 2020/21 through the GP Access Funds which will see investment of £6 per head of population in 2016/17and 2017/18 rising to £9 per head in 2020/21.  Primary care services are the front door of the NHS but general practice is under pressure after years of relative under investment.  The General Practice Five Year Forward View sets out a national programme to invest £2.4bn in primary care by 2020/21.  Investment of approximately £23m will come from national transformation funding sources, on a SYB STP footprint, across a 5 year period and in line with national planning guidance the CCG is expected to make available from its baseline allocation indicative sums of £1.3m over the 2 year operational planning period.  This investment will be used to support a number of the schemes identified in this plan particularly those aimed at:   * Supporting and growing the workforce * Improving access to general practice in and out of hours * Transforming the way technology is deployed and infrastructure utilised * Supporting practices to better manage workload and redesign how care is provided   It is recognised that to deliver all of the schemes identified additional funding over and above this level may be required and therefore the CCG will also be seeking to maximise the use of STF funding, Primary Care Commissioning budget, accessing national funding including that for training care navigators and medical assistants and also that to be made available for online general practice consultation software systems.  The principle behind all of our proposed schemes is that there will be an invest to save element and that over the period of the GPFV they will begin to deliver financial and efficiency savings which will ensure affordability and sustainability of Primary Care and the wider system.  The table on the next page sets out the CCG’s current understanding of the sources of investment that will be available to support the delivery of our plans. This excludes the investments already being made in Primary Care and the targeted funding that may become available from central sources.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | 2017/18  £000 | 2018/19 £000 | 2019/20 £000 | 2020/21 £000 | **Total £000** | | STP – Potential but unconfirmed share of £23m | \*1,717 | 906 | 413 | 374 | **3,410** | | Transformational support (implementation of 10 high impact actions) - £3 per head Non recurrently in total across 2 years | 376 | 378 |  |  | **754** | | Investment required as per STP guidance - Primary Care Demand/Growth | 190 | 385 | 592 | 957 | **2,124** | | Primary Care Co-Commissioning- difference between current contracts and allocation - not committed | 461 | 167 | 226 | 709 | **1,563** | | **Total** | **2,744** | **1,836** | **1,231** | **2,040** | **7,851** |   \*2016/17 indicative funding is included in this figure to ensure total investment reflects 5 years total investment.  The CCG will prioritise our plans to ensure that we are able to make the most effective use of available funding as we finalise the detailed proposals and fully understand the likely costs. The developments we will be looking to take forward over the period of the GPFV have been identified earlier in this plan, however for clarity the list below sets out all of the proposals which will require investment over that which we have currently committed. This includes those schemes that we would seek to fund from central funding.   * GP Fellowship Scheme * Practice Nurse and Advanced Nurse Practitioner Training Programme * Extended Vocational Training Scheme * Productive Primary Care Programme * The Practice Doctor * Locality Working * Centralised back office functions * Online Consultations * First Port Of Call / Receptionists as Care Navigators * Care Homes Support   For further detail please refer to Appendix 1.  Further development work is required to develop the detailed delivery models and finalise the costings. This will enable us to identify affordability and prioritise schemes over the next 4 to 5 years in line with the available funding sources. |
| **Support and grow the primary care workforce**  A baseline assessment of workload, demand and supply side numbers.  A plan to:   * develop initiatives to attract and retain GPs and other practice staff, and * develop expanded multi-disciplinary primary care teams? | In Barnsley it has been recognised that the number of GP’s is significantly lower than the England average, with only 54 GPs per 100,000 population against the national average of over 65 per 100,000 population.  As at September 2015 the HSCIC Workforce Census showed the Primary Care workforce for Barnsley CCG was made up of   |  |  | | --- | --- | | Staff Group | WTE in Post | | General Practitioners | 137 | | All Nurses | 67 | | All Direct Patient Care | 48 | | All Admin Non Clinical | 281 |   Further work is required to develop a detailed understanding of the wider baseline position in relation to workload and demand.  As set out earlier in this plan, the current and planned schemes and developments which are aimed at increasing and enhancing the primary care workforce include:   * The Practice Delivery Agreement * Primary Care Healthcare Apprenticeship Training Programme - up to 40 whole time equivalents (wte) Health Care Assistant/Admin Apprentices * Clinical Pharmacists - Up to 15 wte Pharmacists * GP Fellowship -up to 6 wte newly qualified GP’s * Nurse Fellowship and Nurse Training - Increase student placement.   Our plans to support GP practices to increase productivity and release more time for care will also have a positive impact in terms of supporting the primary care workforce. |
| **Improve access to general practice in and out of hours**  A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices  A plan to implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020  A description of how wider primary care (dental, optometry, community pharmacy) will contribute to this plan  A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111. | Providing additional access to general practice, both in and out of hours is a key element of ensuring the Primary Care offer in Barnsley is fit for purpose and able to meet the needs and levels of demand from our patients. This is alongside the schemes identified earlier in this plan to improve capacity and productivity  There are currently 35 practices providing 10.5 core GP hours per day equating to 1,837.5 hours per week.  Practices also provide extended access to primary care as part of the Directed Enhanced Services.  We also currently have a GP extended access pilot in Barnsley which is run by Barnsley Healthcare Federation under an APMS contract (iHeart Barnsley). This provides access to primary care services on an evening and weekend, outside of GP core hours and clinical triage both in and out of hours.  Access to appointments is available weekdays between 6pm and 10pm and on weekends (Saturday and Sunday) between 10am and 1pm at 2 ‘Hubs’. Each hub provides access to GP’s, Advanced Nurse Practitioners and Nurses.  The pilot has been extended to March 2017 after which we intend to continue to deliver the service and will commission this in line with the national GP Access Fund specification, ensuring that the service delivers 30 minutes of additional appointments per 1000 population per week (Approximately 128 hours of appointments).  BHF have developed proposals including a workforce model to ensure that the required level of extended access can be delivered consistently. Plans also include the development of a third iHEART Hub in the East of Barnsley which will improve accessibility in one of the most deprived areas of the Borough.  Building on learnings from Prime Ministers Challenge Fund and Vanguards the CCG plans to align the provision of dental, pharmacy, and eye care services with 7 day medical services and re-profiling urgent care pathways and out of hour’s contracts.  The CCG is also working with our local system providers, BHF (iHeart), South West Yorkshire Partnership NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust and YAS (111) to begin to deliver an integrated urgent and emergency care offer to align with national commissioning standards for integrated urgent care access. The GP Out of Hours service will be procured during 2017/18, with the provider being expected to work with partners as part of this process to identify and deliver innovative solutions to providing integrated services.  This work will involve seeking to integrate services into the wider urgent and emergency care system, providing additional capacity through more effective working and reducing the impact on A & E by ensuring patients have access to the right care at the right time in a way which meets their needs.  Specifications will also be developed to enable better sharing of information, joint capacity and demand planning, direct bookings from NHS 111 and other initiatives to ensure that patients are able to access and have a clear route to access urgent and emergency care without being faced with organisational barriers or issues regarding who to contact when. |
| **Transform the way technology is deployed and infrastructure utilised**  A map of current estates and technology initiatives  A plan to deliver the requirements set out in the GP IT Operating Model 2016/18  A clear primary care estates and infrastructure strategy linked to the wider strategy for integrated out of hospital care.  Confirmation that primary care requirements have been included in Local Digital Roadmaps | Core and mandated GP IT services are provided by eMBED through a national contract.  Barnsley CCG also purchase some locally targeted enhanced Primary Care IT focusing on extended support desk opening hours to support our practices.  Transformational Primary Care IT is delivered through a combination of means including through Estates and Technology Transformation Funding bids for example mobile working; the Local Digital Roadmap and locally commissioned investments into primary care IT transformation for example the Medical Interoperability Gateway all of which have been described earlier in this plan.  The Local Digital Roadmap (LDR) is a system wide plan and reflects the interoperability needs to deliver an accessible digital record through system integration with a number of step changes along the roadmap.  General connectivity and system infrastructure is reflected within the LDR, as is the need to develop mobile working, as shared with us by both the GP Federation and our GP IT Clinical Leads.  Whilst the requirements of Primary Care are included and taken account of in the developments around the LDR, the timing of the Primary Care Maturity assessment information and submission date for the LDR mean that further work is required to ensure the digital maturity needs for primary care are integrated into the LDR plans.  In addition to our work locally, the CCG is working across the STP footprint to develop a digital work stream which encompasses the delivery of LDRs over the STP footprint and increased roll out of assistive and wearable technologies to ensure that we can work towards STP level interoperability to help improve the delivery of patient care across our broader footprint. |
| **Better manage workload and redesign how care is provided**  A plan to improve the capacity in general practice through redesign (eg LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions) | The CCG plan includes a range of schemes aimed at managing the workload and redesigning how care is managed as described earlier in this plan.  To support the work we have also reviewed the ‘Releasing Time for Care’ – 10 High Impact Actions to ensure that our plans will ensure delivery of these actions. The table below provides a summary of the CCG response to the 10 High Impact Actions.  **See Appendix 1** |

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| **Organisational Form**  A description of the current organisational form of general practice within the CCG  The ambition for primary care at scale underpinned by a delivery plan  A description of how the “future state” is linked to the wider strategy for integrated out of hospital care | Barnsley CCG currently has 35 practices serving a registered population of approximately 257,000 people.  The CCG has a strong ambition to support the development and delivery of Primary Care at scale and many of the plans included in this document are intended to move towards achieving this ambition.  As previously described Barnsley already has an at scale GP federation, BHF with 28 of our practices signed up as members.  The whole ethos of our plans for primary care at scale is that it will benefit the whole population and on this basis our work with BHF is focused upon delivering services at scale for the whole population of Barnsley and not just for those patients at member practices. This is evident with the iHEART service which is providing extended access to primary care for all registered patients.  Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one where the people of Barnsley don’t see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other regardless of where patients are seen; be that in hospital, in the community or at home. They won’t experience gaps in care; they are not isolated but supported and empowered by what feels like “one team”, each delivering their part without duplication.  As a result over the last six months the commissioning and provider partners in Barnsley have come together as an accountable care partnership to consider how we can develop a local model of care which achieves the objectives outlined above. Discussions have focused on emerging “new models of care”; those that are being piloted nationally would support us in Barnsley.  Our goal is to dismantle boundaries at the point of delivery of care, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of the Borough where inequalities are greatest. Accountable Care in Barnsley could bring together commissioning and provision of local Barnsley health and care services,  The partners have held a workshop to determine what could work differently and the diagram below outlines the principles on which the ACO must be built.    The partnership has also agreed a direction of travel for the establishment of an out of hospital focused Multispecialty Community Provider (MCP), centred around primary care. The scope and underpinning model of care is yet to be agreed, but current thinking is that the scope should include much of community health care, enhanced primary care services and also possibly elements of social care if this is agreed with Barnsley Metropolitan Borough Council (BMBC). Key elements of the model of care are likely to include:   * The centrality of primary care and clinical leadership * The establishment of Multi-Disciplinary Teams to deliver integrated care for the people of Barnsley – working to ACO principles (as above) * Self-care and prevention * Risk stratification * RightCare principles * Integrated care records * Innovation and new technologies * Neighbourhood/locality hubs   **Locality Alignment** - The CCG will be working with member practices to develop a locality alignment model developing the concept of “Neighbourhuds” – this model will facilitate resources to be wrapped around groups of practices and create a focus for outreaching services and delivering primary care at scale in “Neighbour Hubs”. The initial development of this new model will be focussed on the Community Nursing Review and revised resourcing, the alignment of the 0-19 resources and improved working with care home patients. |
| **Engagement**  A description of the CCG is engaging local primary care professionals (GPs, dentists, pharmacists, optometrists) and the local population and patients in the development and delivery of the Transformation Plan. | The CCG will be working with local primary care stakeholders via its core engagement channels: CCG clinical leadership, Governing Body, Membership Council, Practice Manager’s Forum, Practice Nurse Forum, Local Area Prescribing Committee, and Local Medical Committee as well as with the GP federation. We will also continue to make use of the successful Barnsley Education Support Time (BEST) multidisciplinary programme to engage with GP’s and other practice staff. In addition specific co-production activities will take place for individual workstreams.  Combined with the above, patient and public involvement plans are in place as part of the engagement work to support the Sustainability and Transformation Plan, the Barnsley Placed Based Plan. These engagement activities are supported by a partnership across the local and regional health and care system. This partnership means that there is a cohesiveness and consistency of messages and avoids involvement fatigue.  Public and patient activities and networks in place include: the CCG’s OPEN Network, Barnsley Patient Council, Practice Patient Reference Groups, the Service User and Carer Board, public events/workshops, Patient Procurement Panels, community engagement via Love Where You Live teams, local Ward Alliances/Area Council, Barnsley Community Voluntary Network, Barnsley Equality Forum and Barnsley Reach.  Involving people early and at a formative stage is key and this will drive our engagement approach. |
| **Risks and Mitigation**  A description of the key risks and mitigation - | |  |  | | --- | --- | | **Risk** | **Mitigation** | | **GP Recruitment & Primary Care Work Force**  If the Barnsley area continues to experience a lack of GPs in comparison with the national average, due to GP retirements, inability to recruit etc. there is a risk that:   1. Some practices may not be viable, 2. Take up of LES / DES or other initiatives could be inconsistent 3. The people of Barnsley will receive poorer quality healthcare services 4. Patient’s services could be further away from their home. | The CCG’s Primary Care Development Programme has a workforce workstream.  Links have been developed with the Medical School to enhance attractiveness of Barnsley to students  The CCG continues to invest in primary care capacity.   * The PDA enables practices to invest in the sustainability of their workforce. The innovation Fund saw £0.25m invested in developing new, more efficient and flexible ways of working. * The successful PMCF has enabled additional capacity to be made available outside normal hours via the I heart Barnsley Hubs * The CCG is also creating 6 GP fellowships in partnership. * The CCG has recruited and has plans for further recruitment to support the employment of 40 Health Care Assistants. * The CCG has recruited 15 clinical pharmacists to help take some of the pressure of primary care. | | **Practice Engagement**  If the CCG fails to secure Practice Manager engagement there is a risk that the Primary Care development project will fail to deliver transformation. (e.g. that investment in new diagnostic equipment will not deliver the intended benefits). | CCG Involvement with Practice Manager meetings to facilitate engagement and deliver transformation  Work continues with Practice Managers: the Chair of the Practice Manager Group has been included in the membership of the Primary Care Development Workstream. | | **Provider ownership of Accountable Care Organisation (ACO) development** If the CCG fails to secure system wide ownership of the development of the ACO there is a risk that this programme will fail to deliver transformation. | An Accountable Care Partnership Board has been developed and the organisational development of the ACO is being co-produced with all provider partners. | |
| **Governance**  A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time. | The CCG has agreed this submission with its’s member practices and the content included herein reflect the contents of the CCGs Primary Care Commissioning Intentions for 2017-2019  The Committee structures that will ensure delivery of the plan have been included in diagrammatic form below.  **Head of Primary & Out of Hospital Care Delivery**  **GP Clinical Lead - Primary & Out of Hospital Care**  **Primary Care Commissioning Committee**  **Barnsley CCG Governing Body**  **Barnsley CCG Membership Council**  **ACO Partnership Board** |

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| **Action** | **BCCG Response** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **1. Active Signposting** | |  |  |  |  |  |
| Provide patients with a first point of contact which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional. Receptionists acting as care navigators can ensure the patient is booked with the right person first time. | Roll out First Point of Call programme and develop a Receptionist Care Navigators programme. Increase use of Sound Doctor tools across all practices. Universal Information and Advice in conjunction with the Local Authority development. Continue to enhance the RightCare Barnsley brokerage service. | The CCG established a training programme with Sheffield Hallam University to deliver training in active signposting for general practice reception staff. To date 50% of Barnsley practices have taken part in the course.  Dementia Champions established in each GP practice.  Sound Doctor offered to all practice which enables patients to self-manage specific conditions. | The remaining 50% of practices staff have completed the training.  Taking the learning from local vanguard site on care navigation and by engaging with the local federation and practices the CCG will build on the learning and create a bespoke training programme to be rolled out across Barnsley practices in 2018/19.  Social Prescribing commences on 01 April 2017 and actively signposting patients to the right service.  Exploration of other technologies to sign post patients to the right services. | Evaluate the impact of the care navigation training programme and the impact of Social Prescribers within practice.  Improved use of the Social Prescribing service.    Utilising new technologies and developments to actively sign post patients to the most appropriate service.  Roll out of bespoke programme to Care Navigators to further enhance this resource. | Build on the feedback received on the Care Navigation Service and embed the Social Prescribing service in practices.  Evaluate:  Increase in self-care for patient with Long Term Conditions and the impact on productive workflows – freeing up GP capacity (measures) reduction in DNA’s. | Practices and patients aware of the right services to access.  Services are embedded within Barnsley ultimately releasing time for care for more complex patients in General Practices and have effect on wider health and social care system. |
| **2. New Consultation Types** | |  |  |  |  |  |
| Introduce new communication methods for some consultations, such as email and video consultations. Where clinically appropriate, these can improve continuity and convenience for the patient, and reduce clinical time per contact. | Email, and video conferencing have been piloted as part of innovation fund and iHeart development. Plan to role out different methods across practices. | Pilots within I HEART Hubs for email and video appointments have been trialled and the right technology to support these new developments have been sourced.  LDR baseline position established and a 5 year implementation plan to be paper-free at the point of care’ by 2020. LDR Vision is to support patients to maintain their own health and wellbeing through technology solutions.  35 out of 36 GP Practices signed up to the Medical Interoperability Gateway (MIG) which allows practices and other local health partners to share patient records as part of the LDR 5 Year Plan.  Respond locally to new technology and innovations. | Evaluate the effectiveness of the I HEART email and video pilot and learn best practice.  Role this initiative out to other local practices who are keen to trial this new way of working.  Explore other areas to offer e-consultations such as Apps or online portals.  Continue to roll out the LRD 5 year plan which involves 100% of GP Practices and all health partners signing up to the MIG.  Two ways text messaging system for patients to contact the GP Practice.  Practices Nurses to offer group consultations for patients managing Long Tem Conditions.  All practices to offer a telehealth service. | Role-out Email and Video appointments to all Barnsley practices.  The CCG to develop other consultation types in line with technology and best practice in other areas to best suite Barnsley Patients and practices.  Continue to roll out the LDR 5 year plan.  100% of practices are offering two way texting and telehealth appointments. | LDR successful in achieving a fully interoperable electronic health records so that patient’s records are paperless.  All Health and Social Care Partners, where appropriate are fully utilizing the MIG. | All Barnsley practices offer effective email and video consultations which have improved continuity and convenience and are open to trailing new technologies and e-consultations.  Continue to embed and enhance the success of the LDR and paperless patient records. |
| **3. Reduce DNA'S** | |  |  |  |  |  |
| Maximise the use of appointment slots and improve continuity and capacity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment. | Productive Primary Care to address reduction in DNA.s. Text messaging supported for all practices. BCCG also invested in Voice Connects which is a telecommunication system that allows patients to amend or cancel appointments. | Commissioned Patient Partner system for Barnsley practices which allows patients to book, cancel or change an appointment 24 hours per day. Currently18 practices are using the patient partner system. Assess feedback on the effectiveness of the Patient Partner system.  Practices to work with their Patient Reference Group’s and establish their baseline for DNA’s and to discuss ways to reduce this.  The CCG has a contract with EE which funds SMS text reminders for all practices. | Ensure Barnsley GP Practices to utilise the Patient Partner system supported by the positive feedback from practices who have been using the system.  The CCG to collate ideas from PRG’s to reduce DNA’s and share this across practices. Ensure all practices implement small changes such as patients writing appointments cards and all practices displaying DNA information.  Utilise best practice nationally for reducing DNA’s such as writing to patients with the cost if they DNA and understanding the reasons.  Ensure that 100% of practices are using the SMS text message reminder and develop this into two way texting.  Explore the A & E model for frequent attenders and its application to frequent GP defaulters.  Widening the Practice Team to include appointments with the Clinical Pharmacists, HCA or patients being re-directed to other service through the Care Navigators or Social Prescribers. | Evaluate how the Patient Partner system has benefited Barnsley practices using DNA information and workload data.  Active sign posting initiatives embedded which has an effect on DNA’s as patients are accessing right service and clinician first time. | Patients fully utilising the Patient Partner system and online booking of appointments which has reduced DNA’s in Barnsley.  Workforce initiatives ensure patients access the right clinician at the right time. |  |
| **4. Develop the Team** | |  |  |  |  |  |
| Broaden the workforce, to reduce demand for GP time and connect the patient more directly with the most appropriateprofessional. This may include training a senior nurse to provide a minor illness service, employing a community pharmacist or providing direct access to physiotherapy, counselling or welfare rights advice. | HCA Apprenticeship Programme. Clinical Pharmacists. Community Pharmacists. Minor Ailment Service. GP Fellowship and Nurse Training. Social prescribing (My Best Life). Extension of VTS training scheme. Alcohol workers in practices. Future developments of receptionist roles re care navigation. | The CCG has appointed 15 Pharmacists with a strategic support team of 6 (1 Manager and 5 Administrators) employed to work within GP practices across Barnsley. They have received a co-ordinated induction and development programme.  The development of a primary care training / Health Care Assistant Apprenticeship programme has seen 16 new apprentice placements have been created in GP practices.  Workforce summit held in November 2016 to look at additional ways to develop the practice workforce.  Minor Ailments scheme currently rolled out in conjunction with community pharmacies. | The commissioned social prescribing service (My Best Life) commences 01.04.2017.  Reception staff (as described in Active Signposting) to be trained as Care Navigators.  Roll out the Primary Care Apprenticeships programme to ensure that all practices wishing to host an Apprentice are allocated one.  A scoping exercise will be undertaken to identify the potential for the development of a Practice Nurse and Advanced Nurse Practitioner training programme.  The CCG will implement with partners, a GP Fellowship Scheme, initially for up to 6 newly qualified and new to Barnsley GPs.  Develop the minor ailments intuitive to include more technology e.g mobile app, online portal or triage portal operated by the care navigators. | Embed and enhance the working arrangements between the Care Navigators and Social Prescribers in practice to ensure the services are working in conjunction.  Evaluate the implementation of the Clinical Pharmacists and Apprenticeships Programme to identify best practice, areas for improvement and any requirement of additional resources.  Implement for all Barnsley Practice Nurses and ANP’s a development programme.  Direct Access to therapists on site such as physiotherapist or mental health practitioner. | Evaluate the GP Fellowship model and look at ways to ensure successful recruitment at the end of the 2 year placements. | Barnsley practices have a multidisciplinary Primary Care Team which has reduced the demand on GP’s and ensures that a patient is accessing the right clinician. |
| **5. Productive Work Flows** | |  |  |  |  |  |
| Introduce new ways of working which enable staff to work smarter, not just harder. These can reduce wasted time, reduce queues, ensure more problems are dealt with first time and that uncomplicated follow-ups are less reliant on GPs consultations. | Productive Primary Care to address smarter working practices. | 4 practices have taken up the capacity and demand audit to identify new ways of working.  BHF have worked with the CCG to develop a proposal to provide a full programme of Productive Primary Care across all practices, this has been offered to all Barnsley Practices.  The CCG is developing proposals to deliver increased collaboration and alignment between practices and Care Homes.  Development of 2017/18 Health Inequalities Targeted Scheme (HITS).  Implementation of Map of Medicine in all GP Practices. | Increase to 50% of practices taken capacity and demand audit to gain baseline.  The CCG and partners offer “The Practice Doctor” initiative.  Development of Lean principles to measure, understand and improve common processors to be rolled out across GP Practices.  Build on the First Port of Call training to ensure the reception area is a productive environment.  Widening the practice team to ensure that the patients is accessing the right clinician e.g. clinical pharmacists and HCA’s. | Ensure all Barnsley practices have completed a capacity and demand audit.  Continue to share best practice and where possible corporate policies, processes and procedures across practices to minimise the administration workload.  Ensure practices are utilising all technologies available such as the Sound Doctor, Map of Medicine and Social Prescribers to reduce unnecessary appointments. | An increase in capacity and GP demand with demand being shared across the wider practice team. Staff working smarter utilising technology and all initiates introduced over the GPFV. |  |
| **6. Personal Productivity** | |  |  |  |  |  |
| Support staff to develop their personal resilience, as well as specific skills to allow them to work in the most efficient way possible. This may include improving the environment, reducing waste in routine processes, streamlining information systems and enhancing skills such as reading and typing speed. | Productive Primary Care to address smarter working practices. | CCG to offer, through eMBED Project Manager training to Practice Managers.  Development of a programme to develop Practice Nurses.  FPOC training rolled out to 50% of practices reception staff.  The CCG held a BEST event in December 2016 for speed reading in which 73 GPs attended.  Ensuring all practices are aware of and can access The NHS GP Health Service – providing individual support to manage personal resilience, stress and burnout. | Identify Learning and Development needs of Primary Care staff to enable training packages to be developed.  Ensure Clinical Pharmacists and HCA’s newly appointed to practice have their learning and development needs and ambitions mapped and support is in place within the practice and CCG to progress these.  Mentoring and Peer support schemes to be offered through-out the CCG and Primary Care to develop Primary Care staff.  BEST events planned to focus on training needs identified for clinical members of staff.  Touch typing courses offered to all Primary Care Administration staff.  Streamlining systems, policies and processors to enable practices to adapt ‘off the shelf’ policies to their practice. | Ensure all practices have sent at least 2 members of staff on the touch typing courses.  BEST Tutors to lead on the learning and developing needs for Primary Care embedding these into BEST events where possible.  Utilising technology to reduce administration staff time. | Re-evaluate training and development needs of Practice staff and successful programmes. | Broadened the skills of the Primary Care Workforce with HCA’s, Clinical Pharmacists and Care Navigators . |
| **7. Partnership Working** | |  |  |  |  |  |
| Create partnerships and collaborations with other practices and other providers in the local health and social care system. This offers benefits in terms of improved organisational resilience and efficiency, and is essential for implementing many recent innovations in access and enhanced long term conditions care. | Locality Model in development. BHF - partnership to deliver back office efficiencies. Care Home model in development. PDA - encourages partnership approach to primary care at scale. | Locality model to reflect the electoral wards of the local authority. Links to BMBC Area Councils to support Neighbourhood hubs.  Develop an alignment model between practices and Care Homes and a universal offer to care homes.  Barnsley Healthcare Federation made up of 28 out of 35 GP practice members.  Develop the PDA 2017/18 to encourage Primary Care at scale.  LDR and the MIG rolled out to all practices.  Developing with partners and Accountable Care Organisation.  STP Development. | Neighbourhood hubs and locality model enabling multidisciplinary teams out in the community offering care closer to home.  Ensure all practices are signed up to deliver the PDA 2017/18.  BHF offered a support package to practices for back office and joint administrations functions.  Specialists to be hosted within Primary Care environments to cut down the number of referrals out of Primary Care.  Clinical and Community Pharmacists to work together to build the relationships between the GP Practice and local pharmacy.  Social Prescribers are the key link between GP Practice and Local Authority to direct to social and other services.  Accountable Care Organisation takes form.  Ensure all Local Health partners are signed upto the MIG. | Build on the PDA success to develop and inform future PDA’s.  Localities and cluster practices to work collectively on common issues and with patient groups e.g Long Term Conditions.  BHF offering a successful programme of support to practice who require additional or administration support.  Primary Care Estates built to host multidisciplinary teams.  Local ACO established and functioning. | Services wrapped around patient needs with no boundaries between organisations. |  |
| **8. Use Social Prescribing Independence** | |  |  |  |  |  |
| Examples include leisure and social community activities, befriending, carer respite, dementia support, housing, debt management and benefits advice, one to one specialist advocacy and support, employment support and sensory impairment services. | Social Prescribing has been in place on a small scale since 2015. A new model has been developed and the new larger scale service 'My Best Life' will commence in April 2017. | CCG commissioned a full Social Prescribing Service ‘My Best Life’ to commence 01.04.17.  Established Dementia Champion in each GP Practices who receive training and peer support. | Care Navigators and Practice staff work effectively and in conjunction with the Social Prescribing Advisors based in practice.  Work with the Local Authority to ensure an up to date directory of services is available.  Dementia Champions to attend regular training and meetings to share best practice and maintain key contacts. | Continued training based on the Wakefield Vanguard model to further develop Care Navigators and other Practice Administration staff. | Evaluation of My Best Life by reduced appointments and also patient experience. | Social Prescribers embedded as part of the Team with reduced demand for GP appointments and patients accessing the right service. |
| **9. Support Self Care & Management** | |  |  |  |  |  |
| Take every opportunity to support people to play a greater role in their own health and care. This begins before the consultation, with methods of signposting patients to sources of information, advice and support in the community. Common examples include patient information websites, community pharmacies and patient support groups. For people with long-term conditions, this involves working in partnership to understand patients' mental and social needs as well as physical. Many patients will benefit from training in managing their condition, as well as connections to care and support services in the community. | Place based plan programme to Increase Health Literacy - through universal access to information and advice. Behavioural change training. Year of Care initiative and social prescribing. Sound Doctor system. | CCG rolled out Sound Doctor, Self-Care online management system to all practices to raise with patients who meet the criteria of the initiative.  Nurses in Primary Care to develop ‘bespoke’ group sessions for patients with Long Term Conditions.  Make Every Contact Count initiative established and being progressed to sign post to self-care information.  Dementia Champions established in each GP Practice.  Behaviour change training with Sheffield Hallam University rolled out across Primary Care. | Evaluate how many practices and Barnsley patients are utilising the Sound Doctor system. – Ensure 100% of practices are using the system. Evaluation March 2018.  Care Navigators and Social Prescribers referring patients to the universal access to information and advice for patients, where appropriate, to self-manage.    Roll out the Patient Activation Tool to all practices.  Ensure all practices are equipped with self-care information to display within the practice.  Self-Care publication to be developed with the Patient Reference Groups and the Barnsley Patient Council. | CCG to promote self-care campaigns through social media and practices.  Patient Reference Groups and the Barnsley Patient Council to ‘champion’ self care within the local practices.  Local patient groups established in line with locality models for patients with Long Term Conditions to have peer support. | The development of a reliable and endorsed patient information website where self care information is available from. | Patients aware of and are accessing self care information and feel more empowered to manage their own conditions.  A reduced demand for GP appointments and in contacting Primary Care. |
| **10. Build QI Expertise** | |  |  |  |  |  |
| Develop a specialist team of facilitators to support service redesign and continuous quality improvement. Such a team will enable faster and more sustainable progress to be made on the other nine high impact changes. The team could be based in a CCG or federation. They should ideally include clinicians and managers, and have skills in leading change, using recognised improvement tools such as Lean, PDSA and SPC, and coaching GP practice teams. | The CCG is currently working in partnership to develop an initiative called the Practice Doctor this will build local Quality improvement expertise. Productive Primary Care will also build this expertise. | General Practice Improving Leaders Programme offered to Primary Care Managers, CCG staff and Federation Members.  Development of the Practice Doctor initiative.  Development of a GP Fellowship Model.  Primary Care Development workstream made up of BHF, CCG and Practice Manager Representation to progress the 10 High Impact Actions.  Support with continuous learning from CQC inspections, GP patient surveys and patient feedback, Quality and Improvement assurance process and Building capability for improvement . | CCG and BHF Team, which are a mixture of Managers and Clinicians, have completed the General Practice Improving Leaders programme and are equipped to lead on the 10 High Impact Actions.  CCG to offer development opportunities for Primary Care Nurses.  Practice Doctor Initiative in place and offered to any practices who are in need of quality development and support. | Leadership Team taking forward quality improvement and the GPFV Action Plan. | A high quality Primary Care Service with measurable improved outcomes. |  |